

**Montana Mental Health Nursing Care Center
Department of Public Health and Human Services**

Adverse Drug Event Report Form

Resident Name: _____

Date: _____ **Time:** _____

Name of Medication: _____

Route Administered: _____

Check Items that are applicable:

- 1. The Medication dosage was correct but given to the wrong resident.
- 2. The dosage was greater than or less than that which was ordered.
- 3. The medication was given at the wrong time.
- 4. The medication was omitted.
- 5. The resident received an unordered dose of medication
- 6. The resident received the medication by another route than was ordered.

Brief description of the event: _____

Please list any items that may have contributed to the event: _____

Dr. Notified: Yes

Date _____

Time _____